Division of Health Care Financing and Policy
Reimbursement, Analysis and Payment
FQHC and RHC Supplemental Payment Claim

Supplemental Payment Claim due thirty days after the end of each calendar period.
Send all Supplemental Payment Claims or inquiries to:

Mailing address to the Division of Health Care Financing and Policy:

Reimbursement, Analysis and Payment Unit
The Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89701

Electronic email address to Trish O'Flinn, Reimbursement, Analysis and Payment:

patricia.oflinn@dhcfp.nv.gov

Phone number to Reimbursement, Analysis and Payment Unit:

(775) 684-3764

Provider Name:	
Provider Number(s):	
Person Completing Survey:	
Contact Information:	
	Name:
	Address:
	Address:
	Phone:
	Fax:
	Email:
Signed:	
Date:	

Related Comments:

Medical WRAP Supplemental Payment
Guidelines April 2016

In an effort to fully reflect the Medicaid policy related to the submission, processing and payment of supplemental Medical WRAP claims, the following guidelines will be effective January 1, 2016:

1. The data submitted for supplemental payment will contain only raw data, exported from the FQHC's billing system into an Excel file following the guidelines below. The FQHC will not make any calculations to the data submitted. The following information is required for all line items of all qualified medical encounters submitted for supplemental payment:

(The corresponding Excel format required for each item is listed to the right)

	ITEM	FORMAT
a.	Line Item #	Number (NBR) –(No Formulas or Macros)
b.	Provider ID (NPI)	Text (TX)
c.	MCE Recipient ID	Text (TX)
d.	Medicaid Recipient ID*	Text (TX)
e.	Date of Service	Date (mm/dd/yyyy)
f.	CPT code	Text (TX)
g.	MCE Name	Text (TX)
h.	Total Amount Billed	Currency ($)
i.	MCE Paid Amount	Currency ($)
j.	Other Paid Amount	Currency ($)
k.	Total Paid Amount	Currency ($)
l.	Date of Birth	Date (mm/dd/yyyy)

**The Medicaid Recipient ID must be 11 digits (characters) long. Leading zeros must be manually typed in if not present. It is important to ensure this number remains in text format. The Medicaid Recipient ID must be a valid ID (11 zeros is invalid data).*

Files that contain invalid or incorrect information will be returned to the FQHC for corrections.

2. RAP will run the revised validation process over the raw data submission and calculate the expected reimbursement based on the results. Once these validations are completed by RAP, the FQHC will be notified of the resulting totals and will have five (5) business days to review the data.

3. After five (5) business days or upon notification from the FQHC to proceed, RAP will finish validation and processing of the WRAP data and authorize the appropriate supplemental payment to the FQHC.

Division of Health Care Financing and Policy
Reimbursement, Analysis and Payment
FQHC and RHC Medical Supplemental Payment Claim

Provider Name: **1/0/1900 Provider #:** **Billing Date:**

NBR	*TX*	*TX*	*TX*	*Date*	*TX*	*TX*	*$*	*$*	*$*	*$*	*Date*
Line #	Provider ID Number	MCE-Recipient ID Number	Medicaid Recipient ID # 11-Digits	Date of Service	CPT Code	Managed Care Entity (MCE)	Total Billed Amount ($)	MCE Paid Amount ($)	Other Paid Amount ($)	Total Paid Amount ($)	Recipient DOB
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Dental WRAP Supplemental Payment
Guidelines January 1, 2016

In an effort to fully reflect the Medicaid policy related to the submission, processing and payment of supplemental Dental WRAP claims, the following guidelines will apply to all claims submitted after January 1, 2016

1. The data submitted for supplemental payment will contain only raw data, exported from the FQHC's billing system into an Excel file following the guidelines below. The FQHC will not make any calculations to the data submitted. The following information is required for all line items of all qualified dental encounters submitted for supplemental payment:

(The corresponding Excel format required for each item is listed to the right)

	ITEM	**FORMAT**
A.	Line Item #	Number (NBR) –(No Formulas or Macros)
B.	Provider ID (NPI)	Text (TX)
C.	MCE Recipient ID	Text (TX)
D.	Medicaid Recipient ID*	Text (TX)
E.	Date of Service	Date (mm/dd/yyyy)
F.	CDT code	Text (TX)
G.	MCE Name	Text (TX)
H.	Total Amount Billed	Currency ($)
I.	MCE Paid Amount	Currency ($)
J.	Other Paid Amount	Currency ($)
K.	Total Paid Amount	Currency ($)
L.	Recipient Date of Birth	Date (mm/dd/yyyy)

**The Medicaid Recipient ID must be 11 digits (characters) long. Leading zeros must be manually typed in if not present. It is important to ensure this number remains in text format. The Medicaid Recipient ID must be a valid ID (11 zeros is invalid data).*

Files that contain invalid or incorrect information will be returned to the FQHC for corrections.

2. RAP will run the revised validation process over the raw data submission and calculate the expected reimbursement based on the results. Once these validations are completed by RAP, the FQHC will be notified of the resulting totals and will have five (5) business days to review the data.

3. After five (5) business days or upon notification from the FQHC to proceed, RAP will finish validation and processing of the WRAP data and authorize the appropriate supplemental payment to the FQHC.

Division of Health Care Financing and Policy
Reimbursement, Analysis and Payment
FQHC and RHC Dental Supplemental Payment Claim

Provider Name: **Provider #:** **Billing Date:**

NBR	*TX*	*TX*	*TX*	*Date*	*Date*	*TX*	*TX*	*$*	*$*	*$*	*Date*
Line #	Provider ID Number BILLING	MCE-Recipient ID Number	Medicaid Recipient ID # 11-Digits	Date of Service	CDT Code	Managed Care Entity (MCE)	Total Billed Amount ($)	MCE Paid Amount ($)	Other Paid Amount ($)	Total Paid Amount ($)	Recipient DOB
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